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A Report to the Montana Legislature

Information Systems Audit

Management Information and Cost Recovery System: Claims Processing

Department of Public Health and Human Services

September 2009

Legislative Audit Division

09DP-06

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Members of the IS audit staff hold degrees in disciplines appropriate to the audit process. Areas of expertise include business, accounting, education, computer science, mathematics, political science, and public administration.

IS audits are performed as stand-alone audits of IS controls or in conjunction with financial-compliance and/or performance audits conducted by the office. These audits are done under the oversight of the Legislative Audit Committee which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of six members of the Senate and six members of the House of Representatives.

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LEGISLATIVE AUDIT DIVISION

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September 2009

The Legislative Audit Committee
of the Montana State Legislature:

We conducted an Information Systems audit of the Management Information and Cost Recovery System (MICRS). The Reimbursement Office within the Department of Public Health and Human Services operates and maintains MICRS to assist in recovering expenses paid by the state on behalf of patients at state-operated institutions. Our audit work was performed in conjunction with Performance and Financial Compliance audit work. The overall purpose was to determine the Reimbursement Office's effectiveness in maximizing resources by reviewing aspects of the reimbursement process. This audit addressed the role of MICRS in this process.

Overall, we found controls are in place to ensure MICRS is completely and accurately creating and processing claims. However, we identified business processes within the Reimbursement Office that can be improved; specifically, reviewing access lists for appropriateness, documenting manual processes, removing inefficient processes, and correcting inaccurate reports.

We wish to express our appreciation to the Department of Public Health and Human Services for their cooperation and assistance.

Respectfully submitted,

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Legislative Auditor

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REPORT SUMMARY

Department of Public Health and Services

The Department of Public Health and Human Services (DPHHS) is responsible for managing patient care at the five state-operated institutions. All expenses for treatment and care are initially paid by the state. In order for the state to be reimbursed for the cost of services, DPHHS has established the Reimbursement Office (RO). The responsibility of RO is to identify and bill any means of payment a patient might have, including Medicare, Medicaid, private pay, or private insurance.

To assist in the reimbursement process, DPHHS developed the Management Information and Cost Recovery System (MICRS); a computer system designed to assist RO in tracking patients, generating claims based on services provided, and submitting bills to responsible payers. This system was implemented July 2003 and went through three development phases before becoming fully operational in June 2006.

This audit was performed in conjunction with Performance and Financial Compliance audit work. The overall purpose was to determine RO's effectiveness in maximizing resources by reviewing aspects of the reimbursement process. The results of work conducted by Performance and Financial Compliance auditors can be found in a separate report (08P-12). The intent of this Information Systems audit was to address the role of MICRS in the reimbursement process. Specifically, we established objectives to verify the completeness and accuracy of MICRS data and processing. In addition, audit work was performed to determine if reimbursements are processed in an accurate and timely manner.

Based on audit work, we conclude controls are in place to ensure MICRS is completely and accurately creating and processing claims. However, we identified business processes within the Reimbursement Office that can be improved; specifically, reviewing access lists for appropriateness, documenting manual processes, removing inefficient processes, and correcting inaccurate reports.

Chapter I – Introduction and Background

Introduction

The Department of Public Health and Human Services (DPHHS) is responsible for managing patient care at the five state-operated institutions, which include:

- Montana State Hospital
- Montana Veterans' Home
- Montana Chemical Dependency Center
- Montana Mental Health Nursing Care Center
- Montana Developmental Center

All expenses for treatment and care are initially paid by the state. In order for the state to be reimbursed for the cost of services, DPHHS has established the Reimbursement Office (RO). The responsibility of RO is to identify and bill any means of payment a patient might have, including Medicare, Medicaid, private pay, or private insurance.

The overall mission of RO is to maximize the amount of dollars reimbursed for patient care. Over a year, RO will collect on average $20 million of reimbursements, which is 39 percent of expenditures. To assist in the reimbursement process, DPHHS developed the Management Information and Cost Recovery System (MICRS); a computer system designed to assist RO in tracking patients, generating claims based on services provided, and submitting bills to responsible payers. This system was implemented July 2003 and completed three development phases before becoming fully operational in June 2006.

Audit Objectives

Our audit work was performed in conjunction with Performance and Financial Compliance audit work. The overall purpose was to determine RO's effectiveness in maximizing resources by reviewing aspects of the reimbursement processes. The results of work conducted by Performance and Financial Compliance auditors can be found in a separate report (08P-12). The intent of this Information Systems audit was to address the role of MICRS in the reimbursement process. As a result, we developed the following audit objectives to confirm MICRS can be relied on during the reimbursement process.

- Resident and billing data entered into MICRS is complete and accurate.
- MICRS is accurately creating and processing claims.
- Key system and process controls are in place to ensure reimbursement payments are processed in an accurate and timely manner.

Audit Scope and Methodologies

To meet our audit objectives, the scope of this audit focused on the development and processing of claims in MICRS. Specifically, we looked at MICRS processes occurring after institution data is entered in the system and claims are generated. This involved reviewing system processing, data accuracy, system security, and system performance. To accomplish this, we performed testing of MICRS functionality and controls through a combination of staff interviews, review of agency documentation, observation of MICRS processes, and extraction and analysis of MICRS data using a computer-assisted audit tool.

This audit was conducted in accordance with Government Auditing Standards published by the United States Government Accountability Office. We evaluated the control environment using state law and generally applicable and accepted information technology standards established by the IT Governance Institute.

Audit Overview

Based on our work, we conclude controls are in place to ensure MICRS is completely and accurately creating and processing claims. However, we identified business processes within the Reimbursement Office that can be improved; specifically, reviewing access lists for appropriateness, documenting manual processes, removing inefficient processes, and correcting inaccurate reports.

Chapter II – Data Entry

Introduction

State-operated institutions manually send data required for the reimbursement process to the Reimbursement Office (RO), including medical services provided and number of bed days for patients. When this information arrives at RO, data entry clerks manually enter the data into the Management Information and Cost Recovery System (MICRS). Because completeness and accuracy of data is critical in calculating the correct amount to bill insurers, we verified controls are in place to ensure both completeness and accuracy of data records entered into MICRS.

System Edits Ensure Complete Records

One method of ensuring a complete entry of bed day and service records is the existence of system edits in MICRS. System edits require data necessary to the billing process to be entered prior to saving a record. These system edits are designed to issue error messages and not allow records to be saved if required data fields are not filled. We performed audit work to identify all information necessary to process a service claim. We had RO staff verify data required when entering patient demographic information, entering bed days, and entering service information. We then queried the MICRS database to confirm there are not records with null values in the identified required fields. Audit results indicate all required data fields are entered into MICRS.

Reconciliation Report Is Accurate

Another control in place to verify accuracy of data entry is a reconciliation between the number of bed days identified by an institution and the bed days entered into MICRS over a given time period. If the number of days match, RO staff conclude data was entered accurately based on information provided by the institutions. If the numbers do not march, additional work is performed by RO staff to identify and correct discrepancies.

MICRS generates a report providing bed day totals over a given time period. As the accuracy of the report is a critical component in this process, we performed audit work to verify the MICRS reconciliation report is accurately summarizing patient bed days. To accomplish this, we reviewed the programming script behind the report to confirm the correct data is being accessed and summarized. Based on our review, the report includes a summarization of the correct data and can be relied on to perform accurate data reconciliation.

CONCLUSION

System edits and data reconciliation ensures data input into MICRS is complete and accurate.

MICRS Access Needs Periodic Review

Although we identified controls over data entered into the system, there is additional risk that system data can be inappropriately modified by someone with access to the system. At this point, additional security measures are required to protect MICRS data. Primarily, RO needs to limit access to the system to only those that require access based on job duties. During our audit, we verified RO has an access control process in place where requests to access MICRS are made by an employee's supervisor to RO management, who then determine what level of access, if any, is appropriate. Based on our observation, we found documentation, including signed management approval and written justification, supporting access for each MICRS user.

Even though an access control process exists, we identified four users who still had access to the system but no longer required it. Initially, each of the users required access to MICRS, but subsequently changed jobs or left employment at the Department of Public Health and Human Services, meaning they no longer needed the access. While management makes an initial assessment about need for access, they do not perform periodic reviews to determine if existing access accounts are still appropriate. Industry standards suggest routine review of access lists to identify and remove unnecessary access to a system. The goal of access reviews is to prevent unauthorized access to a system by employees who are terminated or no longer require access. While we did not identify inappropriate access attempts, the potential exists when individuals who no longer require access can gain entry to protected health information in MICRS. RO management was notified of the four exceptions and removed the access.

RECOMMENDATION #1

We recommend the department develop and implement periodic review procedures to identify and remove users who no longer require access to the Management Information and Cost Recovery System.

Chapter III – MICRS Processing

Introduction

Once we verified the controls over input of data into the Management Information and Cost Recovery System (MICRS), we performed audit work to confirm we can rely on the internal system processes to calculate and generate accurate bills. Audit work included reviewing the testing processes implemented by the Department of Public Health and Human Services (DPHHS) and reviewing critical MICRS processes.

MICRS Is Accurately Processing Claims

MICRS was first implemented into production in 2003. Prior to implementation, a series of tests were performed on MICRS to ensure the system was processing as expected and functionality was working to maintain and process claim records. The testing included identifying all possible scenarios MICRS would be used for and verifying MICRS positively handles those scenarios. During audit work, we reviewed documentation to ensure scenario testing had occurred prior to implementation. We also reviewed a sample of scenario tests to determine if tests resulted in positive outcomes.

Although DPHHS conducted scenario testing, once the system was put into production, ongoing use of the system would identify areas where existing functionality could be improved or new functionality needed to be added. In these instances, industry standards indicate a change control process needs to be established, which includes request, development, testing, and approval of all changes prior to implementation into production. During our audit work, we reviewed documentation to verify the existence of change management procedures. We found changes and modifications made to MICRS since implementation have been requested, developed, tested, and approved by RO management.

Conclusion

Considering the scenario testing process completed during development and change management controls, we conclude MICRS can be relied on to accurately process claims.

Process For Work Requests Could Be Improved

Work requests are forms used to document requests for fixing or improving MICRS. Currently, RO staff are expected to fill out work requests and submit them to the

supervisor. The supervisor reviews the request and either submits it to the MICRS developers to proceed with the change or returns it to the requesting user for further research. Based on our audit findings, this is an informal process and is not always communicated or followed.

Although an established change control process exists, we did identify an issue with the work request process. We noted RO staff do not always notify system developers of needed work requests. For example, we identified a situation where an RO billing clerk was aware of a MICRS report outputting inaccurate information; however, MICRS developers had not been issued a work request to fix the issue. Best practices recommend when problems are identified, they are reported so they can be fixed through the established change control process. To meet best practices, MICRS staff should be notifying RO management when problems are identified and submitting work requests.

We also identified another weakness in the work request process that has impacted the ability to properly update MICRS. Best practices suggest user procedures and documentation be kept current. There have been instances where a work request was submitted and changes made to MICRS; however, the new modifications were not communicated to all MICRS users, which negatively impacted their understanding of and ability to use MICRS. One example we identified involved the removal of a data field in MICRS. As a result, a new process was required for data entry. There was limited discussion among staff before this request was activated, and MICRS users' ability to operate the system was impacted.

To ensure the work request process is properly identifying and reporting problems, as well as notifying all users of system modifications, RO management should establish and communicate formal documented procedures and guidelines on how work requests should be submitted. Guidance should also include procedures for communicating and training users on new functionality resulting from system modifications.

RECOMMENDATION #2

We recommend the department implement and communicate formal policies and procedures regarding the Management Information and Cost Recovery System work request process, including:

A. *Developing work requests for identified system issues.*

B. *Communicating and training users on new functionality resulting from system modifications.*

Billing Rates in MICRS Are Accurate

Even if internal processes are working as expected, miscalculations can occur if information entered in the system by RO staff is inaccurate. One example of data entry that can affect MICRS processing and calculations is the input of billing rates. Annually, RO management is required to enter three different rate types that are critical to claim calculations, including:

- Per diem contribution by Veterans Administration for veterans' care
- Bed day rates set by institutions
- Medicare billing rates for services

If rates are not entered correctly, the calculation of reimbursement amounts will be adversely affected. We performed audit work to verify RO management is accurately entering the above rates into MICRS. We obtained documentation containing the source rates developed by the Veterans Administration, DPHHS institutions, and Medicare, and compared these rates with the rates residing in MICRS. The results showed MICRS rates are the same as source rates.

CONCLUSION

We conclude rates in MICRS are the same as source rates.

Automated and Manual Processes Used to Prioritize Billing

As previously concluded, DPHHS implemented scenario testing and change management to ensure MICRS processing is working as expected. This applies to internal processing and calculation, which allows us to rely on MICRS to accurately output bills. However, we did identify one procedure in the creation of bills where internal MICRS processing cannot be completely relied on.

When a patient has multiple resources to pay for services, there is an established order for how resources are to be billed. The following list provides the order resources are generally billed; however, this can vary based on each patient's individual coverage:

1. Medicare
2. Private health insurance
3. Medicaid
4. Other resources, including private pay

DPHHS has programmed MICRS to bill for services in a cyclical order, billing all resources covering a patient until either the cost of service has been completely reimbursed or all available resources have been billed. Because billing the correct resource is such an important element of the billing process, we conducted additional audit work to verify this functionality is working as expected. We reviewed the programming script responsible for running the billing priority cycle. Based on our review, we can rely on the script to accurately run the billing cycle with one exception.

In the event an additional resource is identified during the billing process, MICRS is not designed to automatically restart the billing process and include the added resource. If the additional resource has a higher billing priority than resources already billed, any existing bills needs to be canceled and refunds issued for any reimbursements already collected. The billing cycle should then start over and include the added resource. Because MICRS is not designed to handle these occurrences, RO has implemented a manual process where billing clerks adjust patient records to reflect the added coverage and then restart the process for affected bills. An RO supervisor will initiate refunds for resources that have already paid bills.

While RO billing clerks and the supervisor said they understand this process, it has not been formally documented. We ran a query on MICRS and identified 55 changes over the last three years in priority billing. While this demonstrates RO is addressing changes to billing priority, it also demonstrates these scenarios occur regularly and require RO staff to understand how to properly add new resources and adjust billing.

If RO does not perform the manual adjustment, MICRS will continue to bill the wrong resources. Best practices suggest critical processes be documented to assign roles and communicate responsibilities to minimize the impact when individuals with knowledge of business processes leave or are not available. So, while a manual process is in place, RO should document the process to ensure continuity of service including, assigning roles and communicating responsibilities. The existence of system and manual processes ensure the accurate and complete generation of bills. However, this process can be improved with the documentation of the manual process for adjusting billing priority.

RECOMMENDATION #3

We recommend the department develop documentation assigning roles and communicating responsibilities for the manual adjustment of billing priority.

Generic Account Used to Modify MICRS

Even if good change management procedures are in place, system processing can still be compromised through excessive user access to programming code and database tables. Best practices recommend the developers of a system not be allowed direct access to the programming code and database tables. Developers should make changes in a test environment and those changes should be migrated by a second group. This reduces the risk of those with the greatest knowledge of modifying a system from making unauthorized changes to internal system processing. During audit work, we met with MICRS developers who indicated a process has been established where developers make changes in a test environment and DPHHS database administrators (DBAs) migrate new changes to the production version.

To verify this, we met with DBAs responsible for migrating changes into MICRS. We noted all DPHHS DBAs share a generic account used to modify the MICRS database structure and functionality. We also noted they have not documented who has been granted the generic account. DPHHS faces the risk of not being able to identify unauthorized changes to MICRS because multiple users share the same account. As a result, we could not verify developers were not given access to modify MICRS through the production version. DBAs said they could use their own unique accounts when updating MICRS as opposed to using the generic account.

Oracle databases provide functionality to log updates and the user accounts responsible for the updates. With this functionality activated, DPHHS could review the database logs to identify unauthorized changes. In addition, by using unique accounts to migrate changes, the logs could be used to correlate users with changes made, which provides increased accountability. However, during our discussion with DBAs, we noted the logging functionality has not been activated in the MICRS database, so unique accounts alone would not be useful in identifying unauthorized changes.

RECOMMENDATION #4

We recommend the department:

A. *Implement logging of modifications and updates to the Management Information and Cost Recovery System.*

B. *Require unique accounts when updating or modifying the Management Information and Cost Recovery System.*

Vendor Compliance With HIPAA

Once claims have been processed, MICRS generates a bill. During this audit, we found RO has contracted with a third-party healthcare clearinghouse to format and send bills to insurers. If an entity contracts with a third-party vendor to handle protected health information (PHI), the Health Insurance Portability and Accountability Act (HIPAA) security rule requires the entity to ensure the vendor meets all HIPAA standards. Part of the billing process involves electronic transfer of PHI from MICRS to the healthcare clearinghouse. The clearinghouse will then format the bills and send them to resources through electronic means or traditional mail. To ensure HIPAA compliance, we first reviewed the agreement between DPHHS and the clearinghouse and identified language stating the clearinghouse will follow all HIPAA requirements when handling PHI from DPHHS.

Conclusion

We conclude DPHHS has contracted with a clearinghouse in a manner that is compliant with HIPAA.

Chapter IV – Timeliness

Introduction

During the Performance audit of Reimbursement Office Business Practices (08P-12), auditors identified issues with the amount of time taken to bill for services. Specifically, they noted 70,054 services performed in calendar years 2007 and 2008 have not been billed. By not addressing these services in a timely manner there is a possibility the state cannot be reimbursed as Medicare, Medicaid, and private industry all have about a 12-month window for claims to be submitted or the claim will be declined or penalized. According to 42 USC 1295 (g)(4)(B)(i), if a claim is submitted more than one year after the service has been provided, it is subject to a ten percent reduction. For most private insurance companies, claims are to be received no more than one year from the date of service.

Given the need for timely submission of claims in order to maximize reimbursements, we identified two system-related processes that can be improved to ensure services are billed and submitted in a more complete and efficient manner.

Unbilled Services Report Has Inaccuracies

One control RO has in place to ensure services have been billed is an unbilled service report, which is designed to provide RO staff with a list of services that have not yet been billed. This allows RO staff to identify and address services that are outstanding. However, through audit work we noted this report is not entirely accurate. Specifically, we found claims that should have been closed but were still considered open in the unbilled services report.

Our findings support an August 2008 finding in a report issued by the department's internal audit function. During internal audit work, it was determined "The current unbilled services report contains errors and does not work very well." Additionally, the internal audit stated, "Unbilled services should be a high priority for Institutional Reimbursement [RO] to insure they have billed for all services provided." A recommendation was made that the unbilled services report be corrected to allow billing clerks to easily identify unbilled services. It was also recommended the billing clerks need to provide programmers with information needed to develop a workable unbilled services report for each resource.

While the department has improved the unbilled services report, we found instances where services listed on the report are not billable to insurers, or could not be billed due to lack of parient resources to pay. Since the unbilled services report was created to identify legitimate services that need to be billed, unbillable services should not be

included on the report. Currently, the department does not have controls in place to ensure all nonbillable services are closed and do not appear on the unbilled services report. The current report makes it difficult for billing clerks to identify the difference between services that should be billed and services that cannot be billed. By excluding services that are not billable, billing clerks would have a workable unbilled services report.

RECOMMENDATION #5

We recommend the department update the unbilled services report to include only billable services by:

A. *Developing and implementing procedures to identify and close nonbillable services.*

B. *Updating unbilled services report to remove services that have been closed.*

Department of Public Health and Human Services

Department Response

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

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September 15, 2009

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SEP 15 2009
LEGISLATIVE AUDIT DIV.

Dear Mr. Rice:

The Department of Public Health and Human Services has reviewed the information systems audit titled Management Information and Cost Recover System: Claims Processing (09DP-06) completed by the Legislative Audit Division. Enclosed you will find our responses to each recommendation, the expected corrective action and a planned completion date.

We appreciate the effort that your staff put into this audit and look forward to using these recommendations to continue improving business processes in the Reimbursement Office.

Sincerely,

Anna Whiting Sorrell
Director

Cc. Staci Roope
Dan Forbes
Laurie Lamson
Marie Matthews

Recommendation #1

We recommend the department develop and implement periodic review procedures to identify and remove users who no longer require access to the Management Information and Cost Recovery System.

Response: Concur

Corrective Action: The existing user list has been reviewed and all unnecessary access removed. In addition, the Reimbursement Office has implemented a process to review the access list quarterly.

Expected completion date: Completed

Recommendation #2

We recommend the department implement and communicate formal policies and procedures regarding Management Information and Cost Recovery System work request process, including:

A. **Developing work requests for identified system issues.**
B. **Communicating and Training users on new functionality resulting from system modification.**

Response: Concur

Corrective Action: The Reimbursement Office management is working closely with the Technology Services Division to formalize the communication of requested and completed workflows. Once the process is agreed upon the Reimbursement Manager will draft procedures to document the expected approach to system changes in the future.

Expected completion date: 10/31/2009

Recommendation #3

We recommend the department develop documentation assigning roles and communicating responsibilities for the manual adjustment of billing priority.

Response: Concur

Corrective Action: The department will develop desk procedure manuals including tasks related to manual adjustments of billing priority.

Expected completion date: 03/31/2010

Recommendation #4

We recommend the department:

A. **Implement logging of modifications and updates to the Management Information and Cost Recovery System.**

B. **Require unique accounts when updating or modifying the Management Information and Cost Recovery System.**

Response: Concur

Corrective Action: The Technology Services Division will implement a logging process for all modifications or updates to the MICRS system in conjunction with the use of unique user accounts.

Expected completion date: 12/31/2009

Recommendation #5

We recommend the department update the unbilled services report to include only billable services by:

A. **Developing and implementing procedures to identify and close non billable services.**

B. **Updating unbilled services report to remove services that have been closed.**

Response: Concur

Corrective Action: The department will review programming options for a functional unbilled service report. In addition, the desk manual project will include procedures to ensure consistent review and action based on the report.

Expected completion date: 12/31/2009